

College Bound Scholarship Program Data

Application for public and non-profit agencies to receive data to provide assistance and academic support services to College Bound Scholarship students.

Directions for Agency Administrator:

1. Complete ORGANIZATION INFORMATION section.
2. Complete CONFIDENTIALITY/NON-DISCLOSURE AGREEMENT for **each staff member** who will access College Bound Scholarship student data.

Upon approval by the Washington Student Achievement Council:

1. The Agency Administrator will receive written notice that the request has been approved.
2. The Agency will receive instructions to access the reports from the Council's secure portal.
3. Reports for students in the Agency's service area will include the following: students' names, schools/districts, grades, expected graduation years, and FAFSA status.
4. Access will be for one year and will be revoked if the terms of the agreement are not met.

ORGANIZATION INFORMATION

LEGAL NAME: _____

ADDRESS: _____

PHONE: _____

WEBSITE: _____

ORGANIZATION ADMINISTRATOR'S NAME: _____

EMAIL: _____

TAXPAYER ID NUMBER (TIN): _____

TYPE OF ORGANIZATION: (circle one) PUBLIC PRIVATE NON-PROFIT

SUMMARY OF ORGANIZATION'S PURPOSE OR MISSION STATEMENT:

DESCRIPTION OF PROPOSED METHOD(S) FOR CONTACTING COLLEGE BOUND STUDENTS:

DESCRIPTION OF PROPOSED STRATEGIES FOR SIGN-UP AND/OR ACADEMIC SUPPORT OF COLLEGE BOUND STUDENTS:

SCHOOL DISTRICT(S) TO BE INCLUDED IN APPLICANT'S SERVICE AREA:

CONFIDENTIALITY/NON-DISCLOSURE AGREEMENT

Each Authorized Representative of _____ (name of organization) **who will have access to student information must complete and sign and return this Confidentiality/Non-disclosure Agreement.**

As an Authorized Representative of _____ (name of organization), I have access to information regarding College Bound Scholarship students provided by the Washington Student Achievement Council. This information is confidential and I understand that I am responsible for maintaining this confidentiality.

I understand that the information may be used solely for informing sign-up efforts and providing academic guidance and support. I understand that this information shall not be re-disclosed for another purpose or to another party without written permission from the Washington Student Achievement Council.

- I have been informed and understand that all information is confidential and may not be disclosed to unauthorized persons. I agree not to divulge, transfer, sell, or otherwise make known to unauthorized persons any information provided by the Council.
- I understand that I am not to link data provided by the Council with other data or data sets without written permission from the Council.
- I also understand that I am not to access or use this information for my own personal information but only to the extent necessary and for the purpose of performing my assigned duties as an employee of _____ (name of organization) under this Agreement. I understand that a breach of this confidentiality will be grounds for disciplinary action, which may also include termination of my employment and other legal action.
- I agree to abide by all federal and state laws and regulations regarding confidentiality and disclosure of the student information.

AUTHORIZED REPRESENTATIVE INFORMATION:

NAME: _____

TITLE: _____

EMAIL: _____

PHONE: _____

SIGNATURE of AUTHORIZED REPRESENTATIVE

DATE

I agree that only authorized individuals (those who sign and return the attached Confidentiality/Non-disclosure Agreement to the Washington Student Achievement Council) may access the information and that by law we are required to protect confidential information. Furthermore, it is agreed that if the terms of this agreement are not met, access to data will be revoked.

ORGANIZATION ADMINISTRATOR APPROVAL:

NAME: _____

SIGNATURE OF ORGANIZATION ADMINISTRATOR

DATE

Return this application to:

Beth Ahlstrom, CBS Program Administrator
Washington Student Achievement Council
PO Box 43430
Olympia, WA 98504-3430